5 HEALTH HISTORY

Physician's Name _____ **Date of last visit** _____

Please Circle Yes or No to indicate if you have had any of the following:

AIDS	Yes	No	Diabetes	Yes	No	Kidney Disease	Yes	No	Sinus Trouble	Yes	No
Anemia	Yes	No	Emphysema	Yes	No	Liver Disease	Yes	No	Skin Rash	Yes	No
Arthritis, Rheumatism	Yes	No	Do you Wear			Low Blood Pressure	Yes	No	Special Diet	Yes	No
Artificial Heart Valves	Yes	No	contact lenses?	Yes	No	Mitral Valve Prolapse	Yes	No	Stroke	Yes	No
Artificial Joints	Yes	No	Epilepsy	Yes	No	Nervous Problems	Yes	No	Tonsillitis	Yes	No
Asthma	Yes	No	Fainting/Dizziness	Yes	No	Pacemaker	Yes	No	Tuberculosis	Yes	No
Back Problems	Yes	No	Glaucoma	Yes	No	Swelling of feet/ankles	Yes	No	Ulcer	Yes	No
Bleeding Abnormally with			Headaches	Yes	No	Are you pregnant	Yes	No	Venereal Disease	Yes	No
extractions or surgery	Yes	No	Heart Murmur	Yes	No	If so, Due date _____			Osteoporosis	Yes	No
Blood Disease	Yes	No	Heart Problems	Yes	No	Are you nursing	Yes	No	Jaundice	Yes	No
Cancer	Yes	No	Hepatitis	Yes	No	Psychiatric Care	Yes	No	Jaw Pain	Yes	No
Chemical Dependency	Yes	No	Type: _____			Radiation Treatment	Yes	No	Weight Loss	Yes	No
Chemotherapy	Yes	No	Herpes	Yes	No	Respiratory Disease	Yes	No	Unexplained	Yes	No
Circulatory Problems	Yes	No	High Blood Pressure	Yes	No	Rheumatic Fever	Yes	No	Tumor or growth		
Cogenital Heart Lesions	Yes	No	HIV Positive	Yes	No	Scarlet	Yes	No	on head or neck	Yes	No
Thyroid Problems	Yes	No	Swollen Neck Glands	Yes	No	Shortness of Breath	Yes	No	Cough Persistent		
Cortisone Treatments	Yes	No	Swelling of ankles	Yes	No	Tumor or growth on			or bloody	Yes	No
			or feet			head or neck	Yes	No			

MEDICATIONS

List medications you are currently taking:

_____

_____

_____

_____

_____

Pharmacy Name: _____

Phone:

ALLERGIES

Please circle yes or no

Aspirin	Yes	No	Local Anesthetic	Yes	No
Codeine	Yes	No	Penicillin	Yes	No
Iodine	Yes	No	Sulfa	Yes	No
Latex	Yes	No	Other: _____		
			_____	Yes	No

Patient's Signature: _____ **Date:** _____

6 UPDATES (To be filled in at future appointments)

Date: _____

Has there been any change in your health since your last dental appointment: Yes No

For what conditions? _____

Are you taking any new medications? Yes No If so, What? _____

Patient's Signature_____ Date: _____

Dentist Signature _____ Date: _____

UPTOWN Family Dentistry

1 PATIENT INFORMATION

Date: _____

Patient Name: _____

Address: _____

City _____ State _____ Zip _____

Sex: M F Age: _____ Birthdate: _____

Single Married Widowed Separated Divorced

Patient SSN: _____

Occupation: _____

Employer: _____

Employer Address: _____

Employer Phone: _____

Spouses Name: _____

Birthdate: _____

Occupation: _____

Spouses Employer: _____

Whom may we thank for referring you? _____

_____

2 DENTAL INSURANCE

Responsible Party (**if under 18 list parent name**): _____

Relationship to Patient: _____

Insurance Company (**listed on ins card**): _____

Group # _____

Is patient covered by additional insurance? yes no

Subscribers Name: _____

DOB: _____

Relationship to Patient: _____

Insurance Co. _____

Group # _____

Assignment and Release

1. The undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any otherwise payable to more for services rendered, I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all Insurance Submissions.

Responsible Party Signature: _____

Relationship _____ Date _____

3 PATIENT INFORMATION

Cell Number: _____ Home Phone: _____ Email Address: _____

Work Phone: _____ Ext: _____ Spouses Work Number: _____

Best time and place to reach you _____

IN CASE OF EMERGENCY CONTACT (Specify someone who does not live in your household)

Name: _____ Relationship: _____

Home Phone: _____ Other Phone: _____

4 DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental x-rays _____

Please circle Yes or No to indicate if you have the following.

Bad Breath	Yes	No
Grinding Teeth	Yes	No
Dry Mouth	Yes	No
Burning Sensation on tongue	Yes	No
Chew on one side of mouth	Yes	No
Cigarette, pipe, cigar smoking	Yes	No
Clicking or Popping Jaw	Yes	No
Jaw Pain or tiredness	Yes	No
Fingernail Biting	Yes	No
Food Collection between teeth	Yes	No
Gums swollen or tender	Yes	No
Lip or cheek biting	Yes	No
Loose Teeth or broken fillings	Yes	No
Mouth breathing	Yes	No
Mouth pain when brushing	Yes	No
Orthodontic Treatment	Yes	No
Pain around ear	Yes	No
Periodontal treatment	Yes	No
Sensitivity to cold	Yes	No
Sensitivity to heat	Yes	No
Sensitivity to sweets	Yes	No
Sensitivity when biting	Yes	No
Sores or growths in mouth	Yes	No

How often do you floss_____

How often do you brush _____